

A review of recorded information given to patients starting to take clozapine and the development of guidelines on disclosure, a key component of informed consent

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Clozapine is a very effective drug with both significant benefits and significant risks in treatment-resistant schizophrenia. Informed consent is generally accepted as both desirable and necessary in order to ensure that the patient's human rights and dignity are respected. Disclosure is a key element of informed consent. It is unclear if the adequate documentation of disclosure is standard practice before initiation of clozapine. The aim of this study was to assess the adequacy of the documentation of disclosure in consent to clozapine treatment in an adult mental health service and to develop guidelines on disclosure. The method was a retrospective analysis of charts of patients given clozapine who received the drug through the pharmacy of a single North Dublin psychiatric hospital. Results show that current practice has evident gaps. The professional, ethical and legal issues are discussed.

Competency to decide can be assessed by examining its component parts—the ability to understand relevant information, to appreciate the nature of the situation and manipulate information rationally and to express a choice.² Informed consent is the process by which patients can participate in choices about their healthcare. It originates from the right of patients to direct what happens to their bodies—the principle of autonomy and self-determination—and from the ethical duty of the doctor to involve patients in their own healthcare decisions.

Schizophrenia is a chronic, severe and disabling illness. Antipsychotic medications, available since the mid 1950s, have greatly improved the outlook for individual patients. These medications reduce the psychotic symptoms of schizophrenia and usually allow the patient to function more effectively and appropriately. Antipsychotic drugs are the best treatment now available, but they do not “cure” schizophrenia or ensure that there will be no further psychotic episodes.

A number of new antipsychotic drugs (the so-called “atypical antipsychotics”) have been introduced. One of these, clozapine, has been shown to be more effective than others, although the possibility of severe side effects—in particular, agranulocytosis—requires that patients taking clozapine be monitored with blood tests every 1, 2 or 4 weeks. “Treatment-resistant schizophrenia” is defined as schizophrenia in patients who have failed to show an acceptable response to two different standard antipsychotics given separately in adequate doses for an adequate time (6–8 weeks). Although a pivotal study in the late 1980s³ proved that clozapine was more effective than the conventional antipsychotics, its use is restricted to those with treatment-resistant schizophrenia, because of its side-effect profile. Common adverse effects of clozapine usually include sleepiness, dizziness, rapid heartbeat, constipation, excess saliva production and weight gain. Another important adverse effect that occurs commonly is orthostatic hypotension. These effects are usually mild and usually go away within the first few days after treatment is started or a dose is increased, and they can be managed by dose adjustment or other simple interventions. Up to 1% of patients who take clozapine will develop agranulocytosis, a dangerous and potentially fatal condition in which the white blood cell count drops dramatically (0.7% in first year on treatment and 0.07% in second year, with 1 in 11 000

Medical best practice includes obtaining informed consent before initiating treatment. This was not always so. The 19th and 20th centuries saw a consistent development in how consent to medical treatment was conceptualised—from simple consent, where failure to object to a course of treatment when it was explained was accepted as consent, to more explicit choice in the recent past. Respect for individual choice has seen an emphasis on individuals and their human rights.¹ Previously, there has not always been a need to discuss the risks of treatment, as this very discussion was perceived as a danger—it might “demoralise” the patient. The so-called “therapeutic privilege” was invoked by the benign doctor.

A series of legal cases brought a move to emphasise the right to receive sufficient information about the choices that a patient faced. Three elements in such decision-making—disclosure, voluntary choice and competency—were emphasised as key elements before a decision could be considered valid. These elements are not always easy to establish. Disclosure entails explaining the nature and purpose of the proposed treatment, the potential benefits and risks, and alternative approaches available, along with their associated benefits and risks. Voluntary choice implies absence of coercion. Competency implies that state in which patients' decision-making capacities are sufficiently intact for their decisions to be honoured (and the converse for incompetence).¹

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resulting in death) (see Novartis Clozaril (clozapine) tablets available from Clozaril Patient Monitoring Service, patient information leaflet and pack, Prescribing Information And Product Information, 2004, and Atkin *et al*).⁴ The patient becomes extremely vulnerable to infections. Fortunately, if agranulocytosis is detected early enough, the condition can be reversed by withdrawing clozapine, though hospitalisation and treatment with medication to stimulate production of white blood cells may be necessary in some cases.

Seizures may occur in roughly 1% to 5% of patients.⁵ Serious cardiovascular side effects—myocarditis and cardiomyopathy—are also possible but very rare (see Novartis, Clozaril (clozapine), a Complete Reference Guide at Your Fingertips, 2003).

In view of these facts, the initiation of clozapine in patients with treatment-resistant schizophrenia should be preceded by adequate discussion with the patients and, if appropriate, their families, outlining the potential benefits and possible side effects of the medication and the alternatives currently available, including no treatment. The discussion and decision to treat should be supported by adequate documentation.

It is generally accepted that complete informed consent requires disclosure that includes a discussion of the following elements:

- the nature of the decision or procedure;
- reasonable alternatives to the proposed intervention; and
- the relevant risks, benefits and uncertainties relating to the decision or procedure and to each alternative.

Informed consent also requires an assessment of capacity, including the patient's understanding and volition, and the free acceptance or not of the intervention by the patient.

This study was undertaken in to see if, in a large Dublin Mental Health Service, the documentation of disclosure process was adequate as judged by a retrospective review of the documentation of the consent process for all patients taking clozapine, an atypical antipsychotic used in treatment-resistant schizophrenia and dispensed through the hospital pharmacy. The elements of capacity and volition were not assessed in this study.

METHOD

This health service provides mental health services to community-based adults of working age in addition to patients attending dedicated services for the homeless mentally ill, those in a locked special care unit and a rehabilitation service. The patients in this study were drawn from a population in Dublin's north inner city. This is a socially disadvantaged area with high deprivation indices. Because of the nature of their illness, many of these patients were given clozapine as soon as it became available in Ireland in 1993. This review was approved by the local multidisciplinary integrated safety and quality committee in the absence of a hospital ethics committee.

The pharmacy department generated a list of all patients ever registered for clozapine through that department. In the majority of registered cases, no clinical decision to subsequently recommend clozapine treatment was made. Therefore, only patients currently alive, still being treated with clozapine and currently attending the service were included in the review. This process generated a preliminary list of 59 patients. Their charts were requested from medical records, and permission to review them was obtained from all treating consultants. Some charts were not available in the medical records department, as some patients who had responded well to clozapine treatment were now resident in community hostels managed by the service. All such locations were visited, except in the case of one location with five patients. The clinical records for 10 patients

were not available for review at the time of recording. The records of one patient had been sent to another service where that patient was now attending and were not available for review. One patient had given consent for treatment while attending another service but was attending this service for ongoing treatment, and records of consent details were not available. One patient was a ward of court and was excluded from the analysis. That left 41 patient records available for analysis and inclusion in the study.

The clinical records were reviewed by a single investigator.

The specific factors for which the clinical records were screened included documentation of the following:

- Was written information offered to the patient?
- Was the clozapine patient information video offered to the patient? (A written patient information leaflet and video are widely available.)
- Was the patient told that clozapine has proven superior clinical efficacy in treatment-resistant schizophrenia (major indication/benefit)?
- Was the patient told that regular blood monitoring is mandatory or the drug cannot be dispensed?
- Was the patient told of the risk of agranulocytosis?
- Was the patient told of the risk of myocarditis as a rare but potentially fatal side effect?
- Was the patient told of the possibility of weight gain, hypersalivation and other minor common side effects?
- Was the patient offered an opportunity to include family or next of kin to support the patient in the decision-making process?

Evidence of documentation of the issues listed above was considered on a yes/no basis—that is, whether there was evidence of discussion of each element or not. The clinical records were reviewed by a single investigator, who was blinded to the name of the treating consultant, though some signatures in the records were identifiable.

RESULTS

The findings for the 41 patients who were given clozapine and whose records were included are summarised in table 1.

DISCUSSION

These results are based on the findings of a review of the clinical records of 41 patients given clozapine who were attending a north Dublin mental health service. This is a significant majority (68%) of the 59 patients receiving clozapine, though it is a small percentage of the 1710 patients on clozapine in Ireland (personal communication, Novartis Ireland Ltd, Feb 2005), and the results may not be an accurate reflection of the situation nationally. In addition, some of the

Table 1 Elements of informed consent verified in clinical records of patients (n=41) given clozapine

Element present	No. (%)
Written information given to patient	0
Patient information video provided	3 (7)
Discussion of benefit/clinical indication	9 (22)
Discussion of need for blood monitoring	7 (17)
Discussion of side effects (generic term)	13 (32)
Discussion of risk of effect on white blood cells	3 (7)
Discussion of risk of cardiac complications	0
Discussion of weight gain or other "nonserious" effects	0
Discussion of input from family or next of kin	8 (20)

most sensitive cases may have been missed, such as those who had clozapine withdrawn because of side effects, those who died while receiving treatment and those who defaulted or moved away.

The level of detail recorded was limited in the majority of clinical records. It is possible and indeed probable that the records do not accurately reflect the verbal discussions that may have taken place. Should the clinical record require review later due to an adverse outcome or medicolegal claim, it is the written record that carries the most weight. In the majority of cases, the clinical records were poor. The results of this review suggest that the practice of documenting information imparted to patients prior to clozapine treatment in this cohort may be leaving both patient and physician vulnerable.

With regard to disclosure and how much information is considered adequate, the law suggests one of two approaches. One is the “reasonable physician” standard: the amount of information that a reasonable member of the medical profession would discuss with patients in a similar situation about this intervention or treatment. This allows physicians to determine how to fulfil their responsibilities by ascertaining what their peers would do and to act likewise. This standard allows the physician to determine what information is appropriate to disclose. This standard is generally considered inconsistent with emerging views on human rights and the goals of informed consent, as the focus is on the physician rather than on what the patient needs to know.

Another approach is the “reasonable patient” standard: what would the average patient need to know in order to be an informed participant in the decision? This patient-oriented standard of disclosure focuses on considering what a patient would need to know in order to understand the decision at hand—and while it is difficult to be prescriptive about what is materially necessary for a reasonable patient to know in order to make that decision, it does put the emphasis on the patient’s rights.

There is no concrete, defined rule for informed consent in Irish law. It is, however, recognised that doctors have a duty of disclosure to patients. Irish law tends to adopt a doctor-centred approach, applying the same rules as are used in negligence cases.⁶ The legal standard for valid consent has evolved over time. In the widely applied case of *Bolam v Friern Hospital* (1957),⁷ doctors are not negligent if they act in accordance with a responsible body of medical opinion, even if other doctors differ. This was modified somewhat in *Dunne v National Maternity Hospital* [1994].⁸ This stated that if doctors’ defense is that they followed a practice that was general and approved by their colleagues, they cannot escape liability if the practice has inherent defects that should be obvious. In general, if practitioners’ conduct in giving information to the patient is consistent with that of a reasonable body of opinion held by comparable medical professionals, then they will not be negligent. However, if the court is not happy with the standard adopted by the profession, it can set a higher standard. Time has seen a shift towards a more patient-centred approach. At present, what is considered adequate information to allow informed consent is decided by individual doctors and their patients—that is, unless or until it is tested in a medicolegal setting or a court of law. Then the judge will be the final arbiter. The recording of disclosed information in this study would in most cases fail both the reasonable-doctor and the reasonable-patient test.

The issue of informed consent for treatment with clozapine and the associated blood tests specific to patients detained under the Mental Treatment Act, 1945 (Ireland) was not addressed in this analysis. It is interesting to note however, that the Mental Health Act Commission in England and Wales has

indicated that blood tests can be seen as an inseparable part of the treatment and therefore fall within the consent-to-treatment provisions of the Mental Health Act, 1983.⁹ ¹⁰ That is, it allows for the administration of clozapine to detained patients who have not given consent and it also considers the necessary blood tests as “treatment” that can be administered without consent under the Act. The Mental Welfare Commission for Scotland has issued broadly similar recommendations.¹¹

The Mental Health Act, 2001 (Ireland)¹² defines “consent”, a welcome development from the 1945 Act. In Section 56, consent

in relation to a patient means consent obtained freely without threats or inducements, where—

- (a) The consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
- (b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

This study did not look specifically at the issue of capacity to consent to treatment, but there was little documented evidence in the clinical records to suggest that this was addressed at the time of consent. Persons who are unable to utilise disclosed information because they lack certain cognitive capacities are not capable of participating in the decision-making process. Yet, even people with severe mental illness may retain their decision-making capacities. It is wise to remember that lack of treatment-related decisional capacity is a common but by no means inevitable correlate of major mental illness—including those patients who are currently in a psychiatric inpatient unit.¹³

Persons are presumed to be competent, and the burden of proving otherwise rests on those who would overturn patients’ preferences and decisions. In this review, the extent of disclosure was found to be suboptimal, and therefore we are unsure of both the degree of informed consent and indeed the validity of consent in persons whose competency to consent has not specifically been addressed. It may be prudent to engage the patient’s family or next of kin, seek a second opinion and in some circumstances seek a medicolegal opinion, as capacity may be impaired in some of those for whom clozapine is being considered.

In addition, patients often feel powerless and vulnerable, and it is easy to allow coercive situations arise in healthcare delivery. Informed consent should be seen as a process. It is an invitation to the patient to participate in his or her healthcare decisions. In addition, the doctor is required to give the patient adequate information in a form and language that the patient understands (Mental Health Act, 2001 (Ireland) Part 4, Section 56 b)¹² and to ensure that the patient understands the issues around treatment (eg, by using an adequate translation service if translation is needed).

The findings of this review strongly suggest that doctors need guidance or training in the documentation of disclosure, which is part of the informed consent process in patients with treatment-resistant schizophrenia who are about to be given clozapine. As a consequence, we have designed a checklist to facilitate doctors in guiding their patients through the disclosure process when commencing clozapine treatment in a manner that provides patients with the necessary information to make an informed decision and allows the doctor record the process properly (see Box 1). Use of this checklist may improve the process by which informed consent to treatment with

Box 1 Clozapine initiation checklist

Patient name and identification details:

Are the criteria for treatment-resistant schizophrenia fulfilled? Yes No

– If No, please explain:

Did the patient receive written information? Yes No

– If No, please explain:

Was the information video offered to the patient? Yes No

– If No, please explain:

Did the responsible clinician discuss the indication/benefits of clozapine? Yes No

– If No, please explain:

Were minor side effects discussed? Yes No

– If No, please explain:

Was blood monitoring discussed? Yes No

– If No, please explain:

Was risk of agranulocytosis discussed? Yes No

– If No, please explain:

Were potential cardiac complications discussed? Yes No

– If No, please explain:

Was family included in discussion? Yes No

– If No, please explain:

clozapine is obtained and recorded. Doctors might also consider using a standardised consent form, once the checklist has been considered prior to the commencement of clozapine. The checklist and such a consent form are evidence of process only. The therapeutic relationship is a key element in ensuring that patients really understand the decision at hand and can relate it to their own situation. Clinical judgment and skill are

needed throughout to ensure due regard for patients' understanding of disclosed information. The doctor is then acting towards a standard that is consistent, transparent and subject to revision as needed.

Today, more and more patients want to participate in decisions about their own healthcare and treatment. This is a consequence of improved health education and health awareness and comes as a welcome result of a more progressive social attitude about the rights of the individual to autonomy and self-determination. Doctors should ensure adequate disclosure of information as part of informed consent, not just because they are legally and ethically bound to, but because both doctors and patients desire it and patients have a right to it.

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